Child Protection Foundation Training

Allegations of Sexual Abuse

Illinois Department of DCFS Children & Family Services

Core Competencies

- Understand the definitions of child sexual abuse and the allegations
- Articulate the procedures for investigating allegations of child sexual abuse

Definition

- “The involvement of children and adolescents in sexual activities they do not understand, to which they cannot give informed consent, or that violates social taboos.”
  - Kempe, *Sexual Abuse: Another Hidden Pediatric Problem*, 1977

Illinois Legal Definition

- **Sexual conduct – any intentional or knowing touching or fondling by the victim or the accused**, either directly or through clothing, of the sex organs, anus or breast of the victim or the accused, or any part of the body of a child under 13 years of age, for the purpose of sexual gratification or arousal

- **Sexual penetration – any contact, however slight,** between the sex organ or anus of one person by an object, the sex organ, mouth or anus of another person, or **any intrusion, however slight,** of any part of the body of one person or object into the sex organ or anus of another person

Characteristics

- Forms of sexual abuse
  - Exhibitionism / voyeurism
  - Fondling / frottage
  - Vulvar coitus
  - Intercourse
  - Pornography
- Psychological or physical coercion
- Manipulation or exploitation
- Misuse of position of authority / trust

Incidence

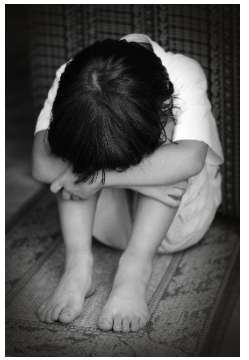
- Accounts for 10% of reported CA/N per year
- Girls
  - About 20% of college-age women report some form of sexual abuse occurring before age 18
- Boys
  - About 5-10% of college-age men report some form of sexual abuse occurring before age 18
- Less than 10% of victims disclose at the time the abuse occurs
- Children are most vulnerable between the ages of 7 and 13

Victims

- Victims: 80% female, 20% male
- Family “risk factors”
  - Single parent home, homes with step-parents
- Younger kids – more often victimized in home
- Older kids – more often victimized out of home
- It is estimated that each year there are about 400,000 children born who will become victims of child sexual abuse

Perpetrators

- 90% are male
- 75 – 90% are known to victim
- 25 – 50% are relatives
- The younger the child victim, the more likely it is that the perpetrator is a juvenile. Juveniles are the offenders in 43% of assaults on children under age 6. Of these offenders, 14% are under the age of 12



THERE ARE NO TYPICAL RISK FACTORS TO PROFILE PERPETRATORS

Presentation & Indicators

- **Crisis**
  - Injury
  - STD
  - Pregnancy
  - Drug overdose
  - Suicide attempt
  - Runaway
- **Behavior problems**
  - Regression
  - Sleep disorder
  - School problems
  - Depression
  - Acting out
  - Inappropriate sexual behavior

Disclosure

- Most child victims never disclose
- Disclosure often delayed (18 months)
- Disclosure often incomplete
- Progression of disclosure:
  - Denial, disclosure, **recant,** reaffirmation

THE HISTORY IS OFTEN THE ONLY EVIDENCE OF SEXUAL ABUSE…

…MOST PHYSICAL EXAMS ARE NORMAL

In the vast majority of cases where there is credible evidence that a child has been penetrated, only between 5 and 15% of those children will have genital injuries consistent with sexual abuse.

https://victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics

Characteristics of Normal Sexual Behaviors

- Consenting
- Developmentally appropriate
- Mutually motivated by curiosity
- Involves pleasurable feelings
- Engage with peers of similar cognitive level

Normal Behaviors

- 2-3 y/o
  - Masturbation
  - Exhibitionism
  - Same/opposite sex exploration
- 6-7 y/o
  - Decreased overt sexual behaviors
  - Curious about sex, dirty words, etc.
- Puberty
  - Sexual activity with peers
  - 1/3 of 9th & 2/3 of 12th graders have had sex

Characteristics of Abnormal Sexual Behaviors

- Coercion or pressure
- Developmentally inappropriate
- Motivated by one child's needs
  - Based on outside influences such as abuse
- Involve pain or discomfort
- Engages with non-peers
  - Older child on younger child

Concerning Behaviors

- Touching adult genitals
- Making adults touch their genitals
- Masturbation with objects
- Masturbation causing pain
- Attempting or simulating intercourse
- Attempting or simulating oral sex
  - RM Reece & S Ludwig. *Child Abuse: Medical Diagnosis and Management, Second edition*, 2001

REMEMBER… THESE BEHAVIORS ARE NOT DIAGNOSTIC AND SHOULD NEVER BE VIEWED IN ISOLATION…

…THESE BEHAVIORS MUST BE CORROBORATED WITH A HISTORY!

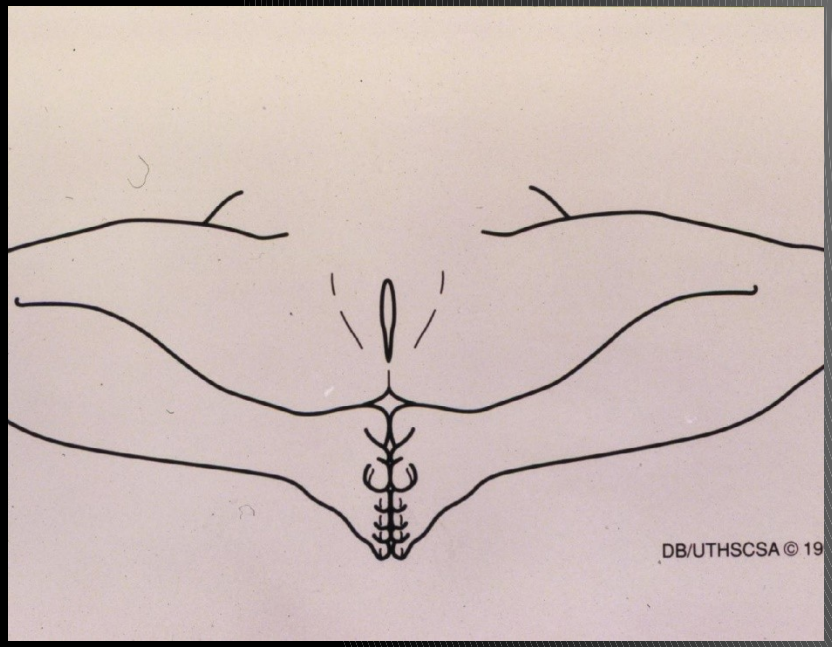
Medical Evaluation – History

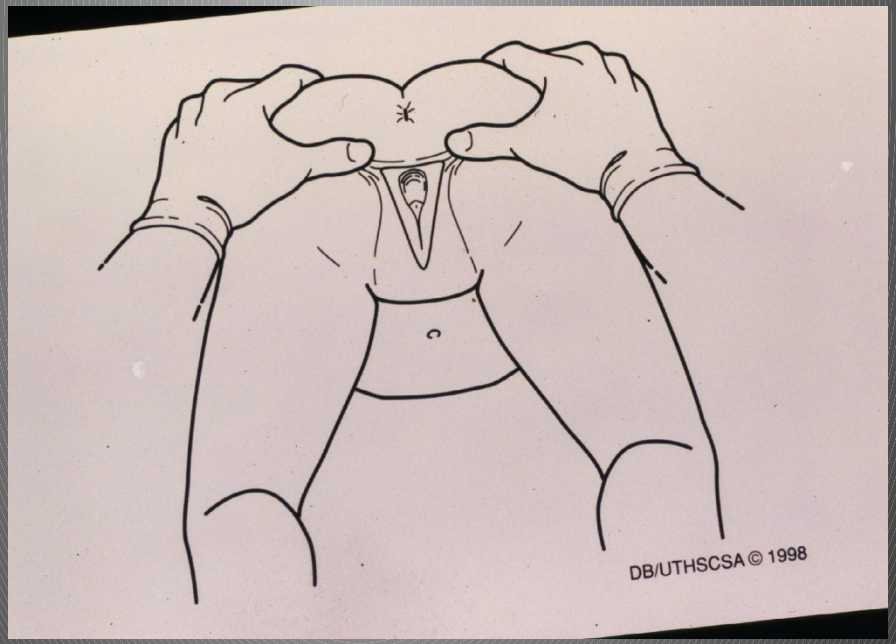
- **HISTORY IS THE MOST IMPORTANT PART OF THE EVALUATION!**
  - Interview child and caretaker separately
    - Interview should be in safe or neutral location
  - Ask open-ended, non-leading questions
  - Use patient's terminology for genital area
  - Use direct quotes in the documentation

Medical Evaluation – Physical Exam

- External visual genital exam in majority
- No speculum used in prepubertal girls
- **Complete** physical exam
- Need for cultures determined case by case
- Need for forensic kit determined case by case

Exam Positions





What is the most common physical finding in sexual abuse evaluations?

A Normal Exam!

75 – 80 % of exams are normal!

Why are most exams normal?

- Nature of sexual abuse
  - Fondling
  - Psychological rather than physical force
- Rapid healing of genital tissues
- Delay in seeking care
  - Disclosure often weeks or months after event
- Genital tissues are highly elastic
  - Tampons, masturbation, etc. do not cause traumatic injury to genital area

What has been the response to sexual abuse?

Children's Advocacy Centers

- County facilities
- Comprehensive approach to services
  - **Offer collaboration of physicians, DCFS, police, state's attorneys**
  - Provide specialized forensic interviews
  - Advocate for the child and family
  - Provide education
  - Refer for necessary services

Goal

To ensure that children are not re-victimized by the very system designed to protect them

Coordinated Approach

- Interview of victim
- Interview of all caretakers
- Interview of alleged perpetrator
- Medical evaluation
- Medical records including
  - Documentation of history obtained
  - Documentation of physical exam
  - Culture results / lab tests
- Police reports

Allegations

- #18 – Sexually Transmitted Diseases
- #19 – Sexual Penetration
- #20 – Sexual Exploitation
- #21 – Sexual Molestation
- #22 – Substantial Risk of Sexual Injury

#18-Sexually Transmitted Diseases

- “A disease which was acquired originally as a result of sexual penetration or sexual conduct with an individual who is afflicted with the disease.”

STD List

- Chlamydia (Chlamydia trachomatis)
- Gonorrhea (Neisseria gonorrhea; GC)
- Genital warts (HPV; Human papilloma virus)
- Syphilis (Treponema pallidum)
- Genital herpes (HSV; Herpes simplex virus)
- Trichomonas vaginalis
- HIV / AIDS
- Pubic lice

Background

- Statistics
  - 2-15% of sexually abused children
- Modes of transmission
  - At birth or in utero
  - Sexual contact

  -- Casual contact?
- Clinical presentation
  - Discharge, rash, pain, bleeding
  - No symptoms

Sexual Abuse Association

- **Gonorrhea certain**
- **Syphilis certain**
- **Chlamydia probable**
- **HPV probable**
- **Trichomonas probable**
- **HSV type 2 probable**
- **HSV type 1 possible**
- **HIV uncertain**

Gonorrhea, Chlamydia, & Syphilis

- Not transmitted thru casual contact!
- Not transmitted thru toilet seats!
- Outside infancy, consider these transmitted through sexual contact

HPV (Warts)

- Difficult to determine etiology
- Incubation period unknown
  - Transmission from birth reported up to 2yo??
  - Large variation in when they are first detected
  - Typing of HPV not helpful
- In children > 2-3yo, HPV highly suspicious for sexual abuse

HSV (Herpes)

- HSV Type 1 – oral (“cold sores”)
  - May transmit to self (autoinoculation)
  - Screen for sexual abuse (i.e. oral sex)
- HSV Type 2 – genital
  - Suspicious for sexual abuse
  - Unlikely but possible from non-sexual contact
- Diagnosis
  - Viral culture
  - Typing important but not diagnostic

HIV

- Reported cases of HIV due to sexual abuse exist
- Incidence of sexual abuse transmission unknown
- Screen all sexually abused children for HIV
  - Positives may be from in utero transmission
  - Important to look at mother’s prenatal screen
- Diagnosis from in utero transmission may be delayed as children may have no symptoms

Procedure

- Forensic Interview
- Re-exam by sexual abuse expert
- Assess safety of environment
  - Removal if perpetrator in home
  - Safety plan if perpetrator unknown
- Follow-up testing as recommended
- Referral for sexual abuse counseling
- Urgent medical exam for siblings / other children in the home

Medical Management

- Pregnancy test
- Tests for other STD's
  - Genital swabs: GC, Chlamydia, HSV, Trichomonas
  - Blood tests: HIV, RPR (Syphilis), Hepatitis B
- Antibiotics
- **Forensic kit if contact < 72 hours**
- **Pregnancy and HIV prophylaxis when needed**

STD testing of caretakers…

- If positive for STD's…
  - May link perpetrator to victim
  - Helpful evidence for prosecution
- If negative for STD's…
  - Does not eliminate perpetrator
    - May clear infection spontaneously
    - May be treated unknowingly
    - May conceal treatment intentionally

#19 – Sexual Penetration

- “Any contact, however slight……”
- “Any intrusion, however slight……”

#21 – Sexual Molestation

- “Sexual conduct [including fondling or inappropriate touching]… for arousal or gratification of sexual needs or desires.”

REMEMBER…

- The history is the most important evidence!

- Physical exam is normal in 75-80%!

Procedures

- Forensic Interview
- Child needs emergent medical exam if
  - Last contact < 72 hours
  - Symptoms such as pain, bleeding, discharge
  - Forensic evidence collection kit needed
- Child needs non-emergent medical exam if
  - Last contact > 72 hours
  - No acute symptoms
  - Safe environment ensured

REMEMBER…

THE CHILD NEEDS AN EXAM BY A PRACTITIONER WITH EXPERTISE IN CHILD SEXUAL ABUSE

The Role of the Medical Provider

- Gathering the medical history
- Evaluating the medical and mental health needs of the child
- Educating families, multidisciplinary team partners, judges, and jurors in the appropriate assessment, interpretation of findings and management of sexually abuse children and adolescents

Adams, J. et al. (2015) Updated Guidelines for the Medical Assessment and Care of Children who may have been Sexually Abused. (In Press) North American Society for Pediatric and Adolescent Gynecology.

Location of Evaluation

- Use the ER only for emergency exams!
  - Chaotic, hurried environment
  - Not child-friendly atmosphere
  - Variable examiner knowledge / expertise
- CAC / sexual abuse expert for non-emergent exams!
  - Calm environment w/ adequate time allotment
  - Child friendly atmosphere
  - Examiner with expertise in sexual abuse

Accidental Injury

- Straddle injury is most common
- Presents with clear history
- Primarily external injury
  - Bruises or cuts on the labia
  - Hymen rarely injured
- Presents with pain or bleeding

#22 – Substantial Risk of Sexual Injury

- Sex offender has access to child
- Siblings / other children in same household as alleged offender
- Persistent, highly sexualized behavior or knowledge in a young child

Procedure

- Forensic interview if indicated
- Medical exam if forensic interview indicative of sexual abuse

Case #1

- 5 year old female seen for vaginal discharge
- No disclosure from child
- No concerns from caretaker
- Physical exam normal
- Cultures positive for Gonorrhea
- Child called back to ED for treatment
- ED reports to DCFS and requests J-response

WHAT ARE THE NEXT STEPS?

Case #2

- 8 year old male reported to DCFS hotline by teacher after disclosing that his uncle “touches [his] booty and [his] private area”
- Taken by police to the ED
- Child repeats disclosure to physician
- Exam is normal

WHAT ARE THE NEXT STEPS?

Case #3

- 2 year old female reported to DCFS hotline by grandmother for suspicion that her “father is messing with her”
- GM’s suspicion based on crying when taken to dad’s home and sexually inappropriate behavior
- No interview / medical evaluation done yet

WHAT ARE THE NEXT STEPS?

Summary – Sexual Abuse Unit

Can you complete a sexual abuse investigation at this time?

What else do you need?

Questions?